

Shoreham-Wading River Central School District  
250B Route 25A  
Shoreham, NY 11786-9745

The Shoreham-Wading River School District nurses would like to take this opportunity to acquaint you with policies related to student medications, general policies regarding illness, immunizations, and physical exam requirements.

New York state law requires the following when a student is to receive medication during the school day:

- A completed form (see attached) signed by the parent/guardian as well as the licensed health care provider.
- The medication in its original container, correctly labeled. Pharmacies are usually very cooperative providing two containers (one for home, one for school) when asked.

This law pertains to ALL medications; both prescription and over the counter. New permission forms must be obtained for each school year. The medication must be brought to the health office by the parent or guardian and picked up during the last week of school. Medication will be kept locked up at all times. If a student needs medication for after school activities, it is the parent's responsibility.

Students ill with a fever, diarrhea, conjunctivitis or vomiting should not return to school until they have been symptom free for 24 hours. Students newly placed on antibiotics should remain home for 24 hours before returning to school. Please notify the school's Main Office, Attendance Office, or Health Office when your child is absent from school. If an illness or injury is significant enough to exclude a student from normal physical activity, a physician's note is required. When the student is able to resume normal activities, a medical note clearing the student from activity restrictions is also required.

All new entrants into the district must provide immunization records complying with New York state requirements. In addition, all incoming 6th grade students are now required to receive varicella (chicken pox) immunizations or medically documented proof of having had the disease. Tetanus, diphtheria, and pertussis (T-dap) vaccines are also now required for 6th graders. Please promptly send proof of immunizations to your student's health office in order to assure uninterrupted school attendance.

New York State requires that all kindergartners, students entering grades 2, 4, 7, 10, and all new entrants into the district have a health examination. Sports physicals satisfy the 7th and 10th grade physical requirements. If written medical documentation of health examinations is not received by the first week in March of the required years, the school physician will examine the student.

A final important reminder: if your child has a serious or life threatening condition, please contact your child's school nurse directly. Thank you.

Sincerely,  
The SWR School District Nurses

Shoreham-Wading River Central School District  
Shoreham, N.Y. 11786  
631-821-8100

**Required Health Examination**

Dear Parents/Guardians,

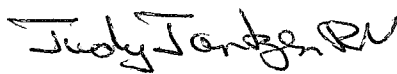
The New York State Education Law requires that every student have a Health Examination in Kindergarten, 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup> and 10<sup>th</sup> grades. A student, when entering a new school district regardless of grade, is also required to have a Health Examination. An examination completed not more than 12 months prior to the beginning of the school year is acceptable. A sports examination will be accepted as the 7<sup>th</sup> or 10<sup>th</sup> grade required health examination.

Health examinations have their greatest value in preventing illness and maintaining health when performed by your child's family physician, physician assistant, or nurse practitioner. We therefore urge you to have your child's health care provider complete the required health examination. The attached form should then be returned to the school Health Office. If your child is not examined by his or her own physician, an examination will be provided by the school physician. You will receive notification prior to the date the school physician will be performing the examination.

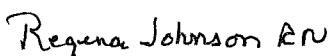
It is also recommended that your child visit the family dentist regularly, since school age children have the highest incidence of tooth decay.

Thank you for your cooperation.

Sincerely,



Judy Jantzen, RN  
School Nurse  
Middle School  
821-8215  
821-8275(Fax)



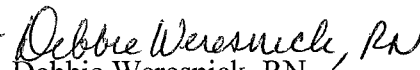
Regina Johnson, RN  
School Nurse  
High School  
821-8170  
821-8153(Fax)



Donna Post, RN  
School Nurse  
Miller Avenue Elementary  
821-8234  
821-8249(Fax)



Cathie Stadnicki, RN  
School Nurse  
Wading River Elementary  
821-8256  
821-8258(Fax )



Debbie Weresnick, RN  
School Nurse  
Briarcliff School  
821-8201  
821-3651(Fax)

**Shoreham-Wading River Central School District**

Shoreham, N.Y. 11786

631-821-8100

**HEALTH EXAMINATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

**IMMUNIZATIONS / HEALTH HISTORY**

Immunization record attached  
 No immunizations given today  
 Immunizations given since last Health Appraisal:

PPD:  Positive  Negative  Not done Date: \_\_\_\_\_  
 Elevated Lead:  Yes  No  Not done Date: \_\_\_\_\_  
 Dental Referral  Yes  No  Not done Date: \_\_\_\_\_

Significant Medical/Surgical History:  See attached \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

**PHYSICAL EXAM**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

U/A : Glucose \_\_\_\_\_ / Protein \_\_\_\_\_

|   |  |   |   |                 |
|---|--|---|---|-----------------|
| Body Mass Index: _____<br>Weight Status Category (BMI Percentile):<br><input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup><br><input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher | Vision - without glasses/contact lenses                      | R | L | <i>Referral</i> |
|   | Vision - with glasses/contact lenses                         | R | L |                 |
|   | Vision - Near Point  | R | L |                 |
|   | Hearing <input type="checkbox"/> Pass 20 db sc both ears or: | R | L |                 |

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis:  Negative  Positive: \_\_\_\_\_

Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

**MEDICATIONS**

Medications (list all):  None  Additional medications listed on reverse of form

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed  Yes  No Student may self carry and self administer medication  Yes  No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

**PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION**

**Please Circle Sport of interest**

physically qualified for all playground, physical education, full contact /collision sports: field hockey, football, lacrosse, soccer, wrestling

\_\_\_ Limited - contact: cheerlead, gymnastic, volleyball, cross-country, baseball, softball, basketball

\_\_\_ Non --contact: golf, tennis, track

Specify medical accommodations needed for school: \_\_\_\_\_  None

Known or suspected disability: \_\_\_\_\_  Please monitor

Restrictions: \_\_\_\_\_  Please monitor

Protective equipment required:  Athletic Cup  Sport goggles/impact resistant eyewear  other \_\_\_\_\_

**ADDITIONAL INFORMATION, if known**

Specify current conditions:  Asthma Diabetes:  Type 1  Type 2  Seizures  Hypertension  
 Other: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp below)

Shoreham-Wading River Central School District  
Shoreham, N.Y. 11786  
631-821-8100

**Administration of Medication**

Dear Parents/Guardians,

New York State law requires the following when a student is to receive medication during the school day:


- 1. A completed form (see attached) signed by the licensed health care provider and the parent giving permission for the student to receive medication during school**
- 2. For students with life threatening allergies, please replace the Administration of Medication form with the pink Allergy Action form**
- 3. The medication in its original container, correctly labeled**

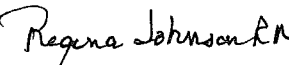
This law pertains to **ALL** medications, both **prescription** and **over-the-counter**. New permission forms must be obtained for each school year.


The medication should be brought to the health office by the parent or guardian. It will be kept locked in the office at all times. Only enough medication for administration during school hours should be sent. For example, if a student requires medication for 5 days, only 5 doses should be sent. Pharmacists are usually very cooperative in providing 2 containers when asked.


Thank you for your cooperation in this matter.

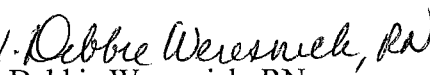
Sincerely,

  
Judy Jantzen, RN  
School Nurse  
Middle School  
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School Nurse  
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821-8201  
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**Authorization For Administration Of Medication**

**A. To be completed by the parent or guardian:**

I request that my child \_\_\_\_\_ grade \_\_\_\_\_ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her medication.:

Signature (Parent or Guardian): \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by the licensed health care prescriber:**

I request that my patient, as listed below, receive the following medication:

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_  
Prescribed Dosage, Frequency and Route of Administration: \_\_\_\_\_

Time to be Taken During School Hours: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Name of Licensed Prescriber and Title (please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**C. Have pharmacist fill & label a separate bottle for the school**

**D. Medication should not be carried to and from school**

**E. Over the counter medications: Original Container with student's name, also requires physician permission**

**F. It is the responsibility of the parent to pick up any unused medication from the school at the end of the year, or it will be discarded**

**G. Permission to administer medication in school has to be renewed by the parent and physician at the start of every school year**

# Allergy Action Plan

Student's

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_



ALLERGY TO: \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

### Symptoms:

- If a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat† Tightening of throat, hoarseness, hacking cough
- Lung† Shortness of breath, repetitive coughing, wheezing
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness
- Other† \_\_\_\_\_

If reaction is progressing (several of the above areas affected), give

The severity of symptoms can quickly change. †Potentially life-threatening.

### Give Checked Medication\*\*:

(To be determined by physician authorizing treatment)

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

### DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_ medication/dose/route

**Other:** give \_\_\_\_\_ medication/dose/route

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ at \_\_\_\_\_

3. Emergency contacts:

| Name/Relationship | Phone Number(s) |           |
|-------------------|-----------------|-----------|
| a. _____          | 1.) _____       | 2.) _____ |
| b. _____          | 1.) _____       | 2.) _____ |
| c. _____          | 1.) _____       | 2.) _____ |

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Date \_\_\_\_\_

(Required)

**SHOREHAM-WADING RIVER HIGH SCHOOL**

250A Route 25A, Shoreham, New York 11786

(631) 821-8265 Fax (631) 821-2428

**Ken Marlborough**

**Director of Health, Physical Education, Athletics and School Nurses**



Dear Parent/Guardian:

Recently New York State Education Law 903 was amended to recommend that students in grades K, 2, 4, 7 and 10 provide a Dental Health Certificate to their attending school. The Dental Health Certificate shall be kept on file in the student's Cumulative Health Record in the school's Health Office.

Attached you will find a copy of the district's Dental Health Certificate which must be completed and signed by a duly licensed dentist. For those families who do not have a family dentist or who cannot afford regular dental service, the providers listed below offer free or reduced fees for dental services.

Adults & Children W/LDD, Inc., 1428 Fifth Ave., Bay Shore, NY 11706, 516-665-1900  
St. Charles Hospital, 200 Belle Terre Rd., Pt. Jefferson, NY 11777, 631-474-6324  
Suffolk County DOH Clinic Service, Riverhead, NY 11901, 631-852-2691  
SUNY Stony Brook Dental School, Nicholls Road, Stony Brook, NY 11794, 631-632-8994

In order to be compliant, the Shoreham-Wading River School District is asking parents/guardians of students whose grade levels are identified above to complete the Dental Health Certificate signed by the attending dentist, and submit the form to the health office of the school which he/she attends. If you have questions regarding this information please contact your child's school nurse or Ken Marlborough, Director of School Nurses, at 821-8265.

Thank you in advance for your cooperation in this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Ken Marlborough". The signature is fluid and cursive, with a large loop at the end.

Ken Marlborough

Director of Health/Physical Education/Athletics/School Nurses

# SHOREHAM –WADING RIVER CSD

## Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

### Section 1. To be completed by Parent or Guardian (Please Print)

|               |       |     |                                    |  |        |
|---------------|-------|-----|------------------------------------|--|--------|
| Child's Name: |       |     | Last                               | First  | Middle |
| Birth Date:   | /     | /   | Sex: <input type="checkbox"/> Male | Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No |        |
|               | Month | Day | <input type="checkbox"/> Female    |  |        |
| School:       | Name  |     |                                    |  | Grade  |

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?  Yes  No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Section 2. To be completed by the Dentist

I. The Dental Health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
- No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp)

Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

### II. Oral Health Status (check all that apply).

- Yes  No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes  No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes  No **Dental Sealants Present**

Other problems (Specify): \_\_\_\_\_

### III. Treatment Needs (check all that apply)

No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.